BLINDED VETERANS OF THE VIETNAM ERA

There is a small group, fewer than a thousand, of easily identified disabled veterans of the war in Vietnam--blinded soldiers, sailors, marines, and airmen. What has happened to this severely disabled group of young Americans since they left Vietnam, the military, and, finally, the Veterans Administration's facilities? In short, when they returned to their respective communities, what happened to their lives?

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BLINDED VETERANS
OF THE VIETNAM ERA

Robert Lee Robinson, Editor

"In war, truth is the first casualty." -- Aeschylus

American Foundation for the Blind, Inc.
New York - 1973

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FOREWORD

Very few "hard" facts are known about the blinded veterans of the Vietnam era, except an estimate of a number -- fewer than a thousand. What has happened to these men? What services are they receiving? What services should they be receiving? What services do they want?

In an attempt to come up with answers to these questions and to provide a clearer picture of some of the unique problems of these blinded veterans, the American Foundation for the Blind sponsored a national research conference April 6 and 7, 1972, in Washington, D.C. The participants included blinded veterans of the Vietnam era and from other wars, and representatives of the Veterans Administration, the Blinded Veterans Association, and other organizations concerned with the delivery of services.

This publication contains a report of that meeting along with other information that we hope will provide a base both for more research and more and better services on both the national and local level.

M. Robert Barnett
Executive Director
American Foundation for the Blind, Inc.

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THE ISSUES

Robert Lee Robinson

There is a small group, fewer than a thousand, of easily identified disabled veterans of the war in Vietnam--blinded soldiers, sailors, marines, and airmen. What has happened to this severely disabled group of young Americans since they left Vietnam, the military, and finally, the Veterans Administration's facilities? In short, when they returned to their respective communities, what happened in their lives?

There has been a dearth of information about this group of blinded veterans, many of whom are severely impaired in addition to being blinded. Many have lost arms, legs, and have suffered hearing impairment as well as blindness.

The conference on the Blinded Veteran of the Vietnam Era posed many questions about the nature and quality of services being offered to him.

While the Veterans Administration did demonstrate that it is initiating new programs and attempting to respond to the needs of the blinded Vietnam veteran, it, nevertheless, seems rather defensive and closed to criticism. Its past history and future plans are cause for commendation, but its service delivery to and research on blinded veterans are not optimally effective.

The Blinded Veterans Association and the Veterans Administration have worked together for twenty-seven years on behalf of blinded veterans. Both organizations have had more experience with veterans of other wars than of the Vietnam War and are experiencing some difficulties in orienting to the different times and different needs of the new group of veterans. Unless the Blinded Veterans Association reaches out more to the newly-blinded veterans of the Vietnam War, it is liable to become an adjunct of the Veterans Administration rather than an advocate for the veteran. History teaches us that few government agencies, regardless of how well intentioned, will proceed as effectively and quickly as possible unless the needs of the people it is serving are kept before it. The Veterans Administration is certainly no exception to the law of government inertia.

Facts

There is a paucity of hard core data about the blinded veterans of Vietnam, beginning with the lack of accurate figures concerning the number of blinded Vietnam veterans and including incomplete statistics on the number of veterans not being assisted by the Veterans Administration.

Linkages

There are breaks in communication between the rehabilitation center counselors and the vocational rehabilitation and education counselors. The veteran experiences bureaucratic difficulty each time there is a disjuncture in planning with and for him.

Program evaluation for the Visual Impairment Service Team

While the New Mexico program was exhibited as a model of the VIST program, more information is needed as to how the other teams function. In preparation for this conference seventy-two teams were asked for information about the blinded veteran of the Vietnam War. Twenty-eight responded. One is led to believe that the caliber of commitment and professionalism in other areas is not as high as in New Mexico.

An issue is raised here as to why all teams should not be headed by the Secretary-Coordinator whose responsibility is dealing with his VIS Team in an effort to deliver coordinated services to the blinded veteran, rather than by a physician, whose role is peripheral.

Time lag

One of the Vietnam veterans at the Conference related that there is delay in obtaining services. It should be possible for the veteran to have all the aids he needs before he leaves the rehabilitation center and to have replacements made immediately, if need be. Any new equipment made necessary by the educational or employment situation should be immediately available.

Accountability and planning

The blinded Vietnam veteran is not involved as he should be on all levels in the planning, implementing, and evaluation of all programs affecting him.

Outreach

One-third of the blinded veterans of the Vietnam War have not gone to rehabilitation centers for the blind. While the rehabilitation center people seem to believe that all blinded veterans should choose to take part in their program, others apparently don't agree. The need to reach all blinded veterans with information about services is imperative. The VIS Teams are welcome and necessary parts of this task. Other possible linkups--BVA, community groups, etc., should be utilized.

Professionalism

The issue was raised and remains unanswered, as to whether counselors need special training to deal with blinded veterans. Would it be better to return to the previous system of special caseloads for the vocational rehabilitation and education counselors? This issue applies to personnel all along the line.

Community attitudes

How can the blinded veteran be helped to cope with the sometimes unsympathetic attitudes of his peers (and others) toward those who fought in the Vietnam War? Much more supportive service needs to be rendered to ease the blinded veteran's reentry into his community, especially since the veteran is moving from a highly structured support situation to a very loosely structured situation in which the degree of support will vary greatly for each veteran. Work has to be done with both the veteran and the community he is about to join or rejoin.

Political pressure

It was said that the relatively few blinded veterans make it difficult for them to be a government budget priority. On the contrary, it seems that just because there are relatively few blinded veterans it should be possible for them to be aided completely, quickly, and effectively without large government bureaucratization.

Family programs

How can the family programs be better integrated into the post center program so that they are more an ongoing program in the community?

Research

Technological research and development seems restricted to improvement and modification rather than innovation. There is a dearth of behavioral-science research in blindness by the Veterans Administration. There appears to be more money budgeted for "hardware" (technological research). There is a lag in evaluation of tangible gadgets and of service programs.

Pipeline failures

In actuality the pipeline exists exclusively for blinded veterans only at the Rehabilitation Centers. At all other times he is dealt with in the larger population of all injured

veterans. Some veterans with multiple injuries go to hospitals to be treated for those injuries other than blindness. These hospitals do not have the personnel or facilities to assist them to adjust to their recent blindness.

In summary, the blinded Vietnam veteran is in the unenviable position of returning home from an unpopular war, often with multiple injuries, to be assisted by an organization which has, for whatever reasons, failed to involve over one-third of the returned blinded veterans in the rehabilitation program.

PROCEEDINGS*

CONFERENCE ON BLINDED VETERANS OF THE VIETNAM ERA

Washington, D. C.
April 6 and 7, 1972

Robert L. Robinson opened the meeting by welcoming the participants to the conference and expressing appreciation that they had taken time from their busy schedules to attend. He introduced Milton D. Graham, who added his welcome, and who was especially delighted to have the Veterans Administration and the Blinded Veterans Association cooperating with the American Foundation for the Blind on this discussion of the problems of the blinded veteran of the Vietnam War.

The idea for the meeting among the three groups originated more than two years ago when Robinson had met with people at the Veterans Administration Central Office to explore the situation of the newly-blinded veteran of the Vietnam Era.

COMBAT EYE INJURIES (Colonel Budd Appleton)

The subject of combat eye injuries is one about which we have had only approximate information in past conflicts. The best estimates indicated that eye injuries accounted for between five and ten percent of the overall combat casualties in World War II and Korea. During the Vietnam Era we have had a tri-service agency called the Armed Services Medical Regulating Office, located within the Army Surgeon General's Office, which has been keeping "pretty good figures." The various types of injuries are coded and given letter designators. The letter designator for an eye injury is "KW" which now makes it possible to assemble accurate information. These data indicate that each year approximately three percent carry only the KW designator as the basis for evacuation, with some variations from year to year. Another three percent carry the KW designator in addition to another designator, sometimes more serious, such as chest or head wounds. From this it has been inferred that the total percentage of eye injuries either alone or combined with other injuries is about six percent. This is scaled on the gross number of combat casualties, varying each year, with a total count in 1971 of approximately 13,500 injuries.

At Walter Reed Hospital the experience had been that approximately half of the veterans who came there who had lost the vision of both eyes had sustained serious injuries to limbs or other organ systems and also that half of eye injuries are isolated and the other half are associated with other injuries.

Since eye-injured veterans take some time to handle they are not immediately sent on to the rehabilitation centers. Considerable time is spent in the hospital to attempt to reconstruct and redevelop some visual capacity where possible. Whenever a man has been identified as having lost vision in both eyes, the hospital notifies the Veterans Administration so that space can be prepared for him in a rehabilitation center, during which time he is getting the maximum benefit of hospitalization.

In conclusion, at the present time there are no cases of eye injuries from the Vietnam War at Walter Reed Hospital and it is hoped this chapter in military eye care can be closed.

Roger W. Little has been making an in-depth study of casualties in Vietnam and their impact on the larger society and quoted figures indicating that discharges from service for impairment of sense organs, which he

*Agenda and participants p.22.

assumed included eye conditions, have tripled since World War II, from 5.6 percent in World War II to 14 percent in Vietnam. The assertion was that conditions of the military environment are becoming much more lethal. He criticized the armed services for not having anticipated such disabling conditions as blindness and for not having developed preventive methods to reduce the incidence of these disabilities. The major change is in the shift from human movement to vehicular movement, both on the surface and in the air, which means that any single accident will involve larger numbers of people due to "bunching up." The contention is that the vehicles themselves are weapons systems. Disability could result from either an accident or the fact that an armored personnel carrier or a tank loaded with gasoline as well as ammunition may be ignited.

Little further stated that a second major category which has changed from previous wars is the increasing incidence of booby traps, rocket-propelled grenades, chemical agents, etc., all of which are likely to be more productive of disability, particularly blindness. Among other recommendations for steps which might be taken to reduce combat casualties were devices to reduce sensory damage. Protective ear devices to shield servicemen from continuous exposure to high-frequency noises on the rifle range, in helicopters, and in artillery firing batteries should be used, as is the case for airlines maintenance personnel. Furthermore, people in the armed forces in hazardous situations where sight is likely to be threatened should be provided with safety goggles.

Appleton made the point that the military have long been aware of the fact that eye armor is not as good as it could be, and that an attempt has been made to improve the quality of such armor. Part of the problem is that eyes lost or injured in combat are from a broad spectrum of missiles, largely in the unstoppable category, and thus not affected or deflected by eye armor. Many eye injuries could be and have been avoided or reduced by ordinary spectacles. Eye armor is provided to combat troops who often remove them because of fogging from sweating or other reasons.

In response to Little's question about early and effective evacuation from combat zones Appleton pointed out that in eye injury very little is lost from delay in evacuation, which may not be true in other types of injuries. An eye may be saved by waiting until the patient can be evacuated to the care of an ophthalmologist. A judicious waiting period is usually better than a patch-up job at a battalion aid station. Not only is the repair of a salvageable eye much more sophisticated now than it was a decade ago, but the use of cortisone steroids for a week or so while the patient is in the process of being evacuated to the care of an ophthalmologist has reduced the incidence of sympathetic ophthalmia.

In general discussion the question arose as to how the number of newly-blinded veterans of the Vietnam War was arrived at; through hospital records, payment of first compensation check (which sometimes showed a lag of as much as a year) or from reports from individual VA stations.

It was agreed that 562 blinded veterans of the Vietnam Era was as accurate a figure as could be arrived at through present means of counting, and that this figure might omit some veterans who had been recently blinded. Malamazian, Apple, and Gillispie reported that 363 blinded veterans had gone to the centers for rehabilitation. Set against these figures was one of 265 which had been reported to Senator Cranston's Committee by the Armed Services Medical Regulating Committee as the total number of blinded veterans of the Vietnam Era. With such obvious discrepancies in the defining and reporting of these casualties, blinded veterans might become lost in the military and VA pipelines.

Robinson asked if there were any identifiable etiological factors causing severe visual impairment and blindness other than combat injuries, and Appleton replied that there had been a tremendous outbreak of foveo-

macular retinitis (central vision loss). This phenomenon eventually became epidemic, and U. S. Army ophthalmologists learned that it was caused by sungazing, resulting in various degrees of loss of sight, and that most of the cases reported had, in fact, retained a good bit of sight in spite of the damage by scar tissue. Robinson said that at the Academy of Ophthalmology and Otolaryngology held in Las Vegas in the Fall of 1971, Commander Bernard Blais, United States Navy, reported that the retinitis may also be one manifestation of a still unidentified systemic disease.[1] (Notes p.18.)

> "What causes the strange and frequently blinding central retinitis that has cropped up repeatedly in military recruits ever since World War II? Roughly 300 cases have been seen at four naval hospitals in the past four years and at least 190 cases have recently been reported by Army ophthalmologists.
>
> "Strong suspicion has been voiced by both civilian and service ophthalmologists that the retinitis is a self-induced disease--the result of solar burns inflicted either consciously to obtain discharge or while under the influence of drugs. The Army, on the basis of a special survey of the controversial foveomacular retinitis (FMR) ordered late in 1970 by the Surgeon General's office has now released new evidence to support this position.
>
> "However, the Navy--which has had a three-phase research program underway since 1969 at the U. S. Naval Hospital, San Diego--has evidence indicating that the retinitis may also be one manifestation of a still unidentified systemic disease.
>
> "The first public report on the findings of the Army Surgeon General's survey was presented during a special symposium at the American Academy of Ophthalmology and Otolaryngology meeting in Las Vegas by Walter Reed's Colonel Budd Appleton. In summing up, he announced that 'it is now reasonable to assume that most cases of FMR are caused by sun-gazing.'
>
> "But Bernard R. Blais told the symposium that, with the second of the Navy's three-phase program now completed, 'the etiology of this retinitis remains in question. The possibility that a systemic disease is involved must still not be ruled out--and that must be done by a case control study.'
>
> "Blais reported that 'with the exception of two possible inadvertent cases of solar trauma, sun-gazing was specifically denied by the remainder of the patients who have been under study at two naval hospitals in San Diego.'
>
> "'There were no common findings in the past medical histories of these patients,' Blais told the symposium. 'And there were no common findings from a battery of laboratory tests --except for the results of the thymol turbidity and cephalin flocculation studies. Thymol turbidity was elevated in 61 percent of the patients, and cephalin flocculation was abnormal in 59 percent--yet all other tests of hepatic function were normal.'
>
> Blais reported that case control studies are now being set up to determine whether the abnormal laboratory findings are routinely associated with the disease--and to rule out or identify a systemic disease that may be generating this retinal lesion.
>
> "Visual acuity varied from 20/20 to 20/200 at hospital discharge in the study patients. But it was 20/60 or better in only 23 percent of the involved eyes; 20/200 or less in 32 percent.
>
> "'And the visual acuity of these patients often does not improve with time.' warned Blais. Of the 72 eyes re-evaluated to date, he reported, 67 percent of those with 20/200 or less vision at discharge had either gotten worse or showed no change."

BLIND REHABILITATION

Russell Williams opened the discussion on rehabilitation of blinded veterans and the VA centers for the blind. He was joined by Loyal E. Apple,

George Gillispie, Edward Glass, John Malamazian, Bobbe Vance and Charles A. Stenger.

Williams discussed the outreach program set up by the Veterans Administration. Contact people at VA stations adjacent to military hospitals go into the hospitals to try to place the VA system in focus for the patients. The contact people are joined in this activity by vocational counselors and social workers in the various VA hospitals. The information gathered is then sent through the VA pipeline to the prosthetic and sensory aids services so that the patient may receive whatever device is necessary, whether for amputation, loss of sight, or other kind of injury.

Stenger spoke on the circumstances and special problems of the Vietnam veteran in general, described the forming of the Vietnam Era Committee about two years ago. Its purpose is to find out about and to understand today's veteran, to investigate the psychological and social needs, and to attempt to learn the values and attitudes of the younger veteran. He mentioned that due to the efforts of this committee, as well as the efforts of similar organizations, the Vietnam veteran is no longer the "invisible" man, but has become highly visible and articulate. He stressed the need to understand the ways in which the Vietnam veterans are different from veterans of previous wars and conflicts and how this difference should be treated.

Stenger pointed out that the veteran of World War II was a product of a prolonged economic depression, whereas the veteran of today grew up and spent his entire life in a period of rapid change and relative affluence. The imprint of these different developmental forces and processes is clearly reflected in his behavior and attitude.

It is generally accepted that the soldier in World War II knew why he was fighting. In stark contrast, the Vietnam serviceman is often ambivalent and uncertain about why he is fighting, why he is there. He knows that the cause for which he fights is controversial and unpopular with much of the American public. He often lacks a sense of patriotic accomplishment in his service and neither expects nor receives a hero's welcome on his return in dramatic contrast to the veteran who returned from World War II to a hero's welcome. In spite of the changing, complex society to which the Vietnam veteran is returning under conditions outlined above, various polls show that he does adjust and in the process has learned to tolerate many of the ambiguities with which he is faced.

He stated further that the Vietnam veteran is not simply a challenge to the VA, but to society as a whole --that due to the lack of stability in the society in which he grew up, and the result of the impact of the Vietnam war controversy, he understandably feels a lack of confidence in institutions of all kinds and the "establishment" in general.

Mrs. Bobbe Vance related her experiences working in VA hospitals with blinded veterans as well as others. She talked about some of their attitudes and how they might have relevance to a rehabilitation program.

Some of the young veterans, including blinded veterans, rejected the rehabilitation programs offered by the VA because they associate the VA with the "establishment," or system. They feel that very little attention is given to them in relation to their individual needs and that they are impersonally categorized.

Most of the veterans were concerned first about work. The second concern was family, even among unmarried veterans who expressed much interest in marriage and a family.

In extensive questioning the veterans said they were interested in jobs that would pay a decent salary and offer opportunity for advancement. This was true of blinded veterans as well as veterans in a psychiatric setting where her research took place.

The young veterans expressed an interest in working for change, even though it meant working within the system to bring about that change. They felt that some of the hostile feelings which were evident would diminish within the next five years

and there would be a meeting of minds between young adults and those over thirty.

Another important finding was that these veterans want to be involved in decisions concerning them. In actual fact some patients, when approached to take part in certain kinds of treatment, refused because they felt that since they had had no part in the design of the program they would not participate. They felt that programs designed entirely by someone else had limited knowledge of the patients' concerns.

This group also said changes were needed in our government. They felt that there should be an all-volunteer army and expressed support for some of the conscientious objectors, although they did feel that the COs should be assigned some kind of duty in the States. They also felt that there should be a change in attitudes toward minorities; that the government should be more involved in seeing that minority groups really did have equal rights.

It had been expected that the young veterans would be interested in drugs, but in fact drugs were not considered to be a problem. The veterans thought smoking marijuana was not really anything to be frowned on and didn't think stringent rules about it were going to change anything. However, they felt that educating young adults about what would happen should they resort to the use of drugs would be an effective method of attacking that problem.

These were the most relevant ideas expressed by the veterans and they might be helpful in developing programs for the blinded veterans.

Williams summarized the development of three rehabilitation centers for the blind at Hines (Illinois), Palo Alto (California), and West Haven (Connecticut), with a total capacity of seventy patients at each facility.

In Malamazian's opinion the blinded veteran of today, despite the various differences everyone had pointed out in this meeting, is still a human being with the same needs and the same desires that all other blinded veterans have. He added that the program the VA offers to the blinded veteran today is much better than the post World War II programs. Since the establishment of Hines VA Hospital Rehabilitation Center twenty-four years ago, the staff had grown immensely, professionally and technically, and that everyone involved had learned a great deal. Today every center has a full-time social worker, a full-time psychologist and a family program, none of which was true after World War II. Visual Impairment Services Teams throughout the Veterans Administration system were set up in 1968.

He indicated that the centers are not completely satisfied with the services offered; there are still gaps, but through the efforts of the VA, the consultants, the BVA and others, the gaps could be closed.

In referring to statistics the three rehabilitation centers had compiled regarding impairments in addition to blindness which make rehabilitation more difficult, he cited brain damage, for which there are no accurate statistics, and hearing impairments. These two particular categories are imprecise in that there are no clear-cut guidelines in establishing what is brain damage and what is a hearing disability.

Of the 363 Vietnam veterans, non-service connected and service connected, who have been through the centers, there were twenty-five veterans who had an upper extremity one side loss; there were four who had loss or loss of use of both upper extremities; twenty-five had loss or loss of use of a lower extremity; nine had loss or loss of use of two sides of lower extremities. Included in these figures were men with extremely serious multiple handicaps; for example, there were six at Hines with bilateral above-the-knee amputations. There are an estimated ninety with brain damage and eighty-two with hearing loss.

George Gillispie emphasized that the newly-blinded veteran is the victim of a gross service-delivery system immediately after onset of blindness while he is still a member of the U.S. military and after he leaves the

centers for rehabilitation of the blind. Further, the centers are the only places at which he receives services from personnel specialized in blindness. Mr. Gillispie went on to point out that the staff assigned to the Visual Impairment Services Teams needs training to deal with blinded veterans out in their communities.

Loyal E. Apple said that one of the programs evolving in rehabilitation centers are more specific ones for veterans who are legally blind but have usable vision. All three centers are also more deeply involved in technological development, in prosthetics/sensory aids research. All the centers have cooperative affiliate programs with universities for training professionals in the field of concern.

Edward Glass expressed his views and conclusions with regard to the psycho-social problems facing the young blinded veteran population. Is he returning to the same kinds of youth culture he left, often against his will? After having been thrust into a culture in Vietnam totally alien to him, which in itself was a shock, then having suddenly incurred a very severe physical impairment, it would be expected that he would have some feelings of bitterness. However, there is generally an absence of bitterness. In the larger Vietnam veteran population there tends to be a continuity. As a whole that group is very articulate, whereas the blinded veteran is not.

There is a cost to these individuals in loss of self-regard, self-concept, and self-respect because of being placed in the lowered category of blindness, which is stigmatizing. However, the young blinded veteran does not talk about this. His main interest is in attempting to re-establish an identification with the youth culture from which he was cut off when taken into service. It has been observed that the young blinded veteran, seeking that identification, may grow long hair, become identified with music--the guitar--reminisce a great deal about his former motorcycling days, upon which he places a great value. In some instances he regains entry into the group by becoming involved in drugs. These are some of the problems that emerge after the veteran leaves the center.

After leaving the center he is thrust into the problem of identifying with his peer group. There are two kinds of forces operating, centripetal and centrifugal; one which is impelling him to follow a normal kind of process, to go to school, go to a vocational institution, or become involved in a trade. The other pull is the feeling of the need to regain identity with his peer group, and especially of his sex norm, which the loss of vision complicates.

VIST EQUALS OUTREACH

Arnold Larson discussed the Visual Impairment Service Teams (VIST). If there are any veterans who are not getting service, the VA needs to know it, because they can provide needed services. The blinded veterans cannot be talked about in the abstract, as numbers; they must be discussed as individuals.

In the VA program the VIS teams are referred to as an outreach activity. In their operation the first step is to locate the service-connected blinded veterans, offer them team services, and follow up on any problems that have been identified. There is one team in Honolulu, one in San Juan, and seventy teams in the continental United States. Each team is composed of a staff physician, who acts as Chairman, a social worker who acts as Secretary-Coordinator, and any other staff member who, in the judgment of the Chairman, would be of assistance to the team as a regular or occasional member.

The person who carries the workload is the social worker coordinator. He does the bookkeeping, makes sure people who are scheduled to report do so, and supervises the entire team operation. The social worker coordinator is the one who should be best informed, have the most knowledge about blindness. Others who serve on the team do so on an ad hoc basis, being called in as needed--prosthetics, VA benefits, vocational rehabilitation--anyone who might be able to help the veteran

in a particular situation, including the chaplain.

The first function of the team is to locate the blinded veteran. Then it is the job of the social worker to visit him in his home, to become fully acquainted with him, his family, his home situation, and to explain the services offered, so that the veteran can avail himself of them or not, as he wishes.

If he accepts the services he is brought into the clinic once a year, at which time he is given a complete review of his situation, complete medical examination, all special examinations, and vocational rehabilitation, as well as a review of his socio-economic situation. Following the visit of the veteran to the clinic, the social worker must then determine what further services are needed.

It is hoped that eventually these VIS teams will become the nerve centers for the entire VA system. They are the groups who should know where every blinded veteran is at any given time. It is the ultimate goal for the social worker coordinator of the team to know each blinded veteran well enough so that should there be a problem the blinded veteran can be contacted without hesitation.

The VIS teams make reports which are consolidated by Robert Schultz and which, along with the field visits to the VIS teams by personnel from the Central Office, indicate how teams are performing. In this regard the VA must maintain a strong public relations effort, a high degree of visibility for programs for the blinded veterans. One method of doing this is to publish the reports of the VIS teams.[2]

Larson concluded by saying that the VA feels it has the best program for blind persons anywhere in the world. He suggested that Santy Sacco, social worker coordinator on the VIS team in New Mexico, discuss the program there.

In 1967 they first determined where the blinded veterans were located. A quality program must be aggressive in reaching out to blinded veterans. He said this has been the approach of his team and it has worked well in providing services to blinded veterans.

The operation of the VIS team in Albuquerque was explained in detail, naming positions of staff who serve on it in one capacity or another, including the Chief of the Outpatient Service, ophthalmologist, psychiatrist, and specialists on prosthetics and sensory aids. Reading materials for the blinded veterans are made available through the Library of Congress program. The team gets out into the hinterlands to develop some awareness among people in general and to promote recognition of the needs of visually handicapped veterans. This is helpful in locating the veteran as well as in providing follow-up services.

Sacco spoke in detail about resistance of the visually-handicapped veteran to services offered by the VA. However, not every veteran is going to accept the program completely and apathy or hostility should not be taken personally by any person working with the visually-handicapped veteran. If the individual veteran does not seem to want to be engaged in the program, the team simply must keep trying. He mentioned that the family programs at the rehabilitation centers are very effective in getting the veteran interested in participating.

The manner in which the team approaches the visually-handicapped veteran has much to do with his response. A generous approach and an appreciation of his feelings relating to his blindness are important. VIS teams can have a great influence on young veterans in terms of what direction they take in their rehabilitation process. It is better not to dwell on the past--Vietnam, his return to the states, military hospitals, negative attitudes toward institutional type living, etc. The relationship should begin with a sense of trying to develop future aspirations for the veteran.

In developing a program it must be looked at as a sustained operation. One of the biggest challenges is to sustain continued interest among the beneficiaries as well as among the people in the community who are sup-

portive of the program. He concluded by saying that the success they had had in Albuquerque had given them encouragement.

A general discussion centered on how many Vietnam blinded veterans were actually in the VIS team program and in the rehabilitation centers. It developed that approximately 200 blinded veterans of the Vietnam war had not gone through the rehabilitation centers. Schultz stated that of the 562 Vietnam blinded veterans who had been identified earlier in the day, over half had been seen in the past nine months by VIS teams, but he felt that through future conferences, training seminars, and reporting, the teams would be so stimulated that there would be a great increase in the very near future. He estimated that more information would be in print by mid-1972.

SENSORY AIDS RESEARCH

Howard Freiberger spoke of VA activity in sensory aids research in connection with blindness.

In preparing for this part of the program he learned how much money was spent in surgery and most other fields of medicine, but not on blindness. It was obvious that money is being spent in that field but it was hard to separate because of imprecise accounting. It is further complicated by the fact that the veteran gets the benefit of Federal programs established not only for veterans but established for all citizens. For instance, in the field of prosthetics and sensory aids research, there are extra-VA inputs of knowledge and counsel from programs such as those of the National Academy of Sciences.

For the fiscal year 1971 the VA expenditure for overall research was $63,139,000. The Prosthetics and Sensory Aids Service spent $2,045,000. Of this amount, Freiberger identified $272,214 spent on contractual research and work at rehabilitation centers for the blind on aids for the blind.

Mentioned were some VA-supported projects such as Haskins Laboratories (reading machines research), for which the average cost-per-annum for fourteen years has been $38,800 but in fiscal year 1971 it was actually $92,000. A million dollars has been expended over a thirteen-year period at Mauch Laboratories, where a variety of reading machines are under development. An average of $34,000 a year for ten years has been allocated to Bionics Instruments for electronic mobility aids, including the laser cane. The laser cane was used by four veterans each at two rehabilitation centers, and it is still being used by them in their home communities in an evaluation program. It is expected that a report will be prepared by Fall 1972 which will be used to determine what will be done with this device in the future.[3] However, an order has already been placed for more of the laser canes, even though the formal evaluation is not yet complete. The original cost of the canes was $5,000, and present cost is $2,800. Thirty-five are on order. He remarked that the cane seems to have promise. It gives information about the environment at a distance greater than a blind person normally gets through his sense of touch.

The VA funds two research employees (specialists) at each of the rehabilitation centers to work not only with mobility devices, but reading machines as well. The mobility specialists evaluate devices such as the laser cane and the ultra sonic spectacles. Thirty of the spectacles have been purchased and over half of them have been delivered and are being evaluated.

The VA is working on canes made of new exotic materials to improve the canes in terms of weight, stiffness, durability, and scuff resistance.

In summation, research was being continued at the three centers on mobility aids, reading machines, closed-circuit television and other devices that may be developed or manufactured as sensory aids to blindness or low vision.

Robinson asked if there is any resistance in the blindness system to new electronic devices such as the laser cane and the head-mounted

ultra sonic spectacles. He also inquired whether there is any on-going behavioral science research in the VA which would indicate which mobility device the blinded veteran finds to be the more enhancing. Freiberger replied that a blind person wants a device that is the least cluttering and the least interfering but it must provide the necessary capability for safe mobility. The VA mobility specialists so far do not seem to think that either the chest-mounted or head-mounted mobility devices are sufficient in themselves to allow the veteran to go home assured that it is a safe system.

Little said that he thought the idea of letting the blinded veteran get around with a cane or a dog seemed to be very limiting. It appeared to him that the centers' interest seemed to be to get the blinded veteran rehabilitated so he could leave the hospital. No thought seemed to be given to helping him find a job and live a normal life, and that none of the discussions mentioned anything about organizations, going to church, joining clubs, or doing all the things other people do in the community.

Malamazian replied that these things are part of the total program.

Larson said that one reason for the reports on the VIS teams is to determine how many of the blinded veterans are productively active; how many are isolated in their own homes, restrained by their relatives and not free to move around, not encouraged to work, nor to take part in some avocational activity or volunteer activity. This too is part of the VA program, although they are not yet satisfied with the information they are getting.

THE BLINDED VETERAN VIEWS HIMSELF

Nancy Coleman, whose doctoral studies in social work and dissertation are concerned with the newly blinded veteran of the Vietnam Era, raised the initial questions: How do you use the knowledge you have? How do you get the most effective service for maximal functioning within community life? How can we use the evaluation and assessment of the blinded veterans themselves to help us to help them function at the highest possible level? These are questions for research. There *is* need to involve the veteran in decision making regarding his future. It should be made explicit how family, staff, and others can support, challenge, and motivate the veteran to move to a higher level of functioning. Various ways should be explored for bringing family and staff into how the veteran views his future as well as his self-concept. Joint planning by all disciplines working with the newly-blinded veteran is needed to extend the boundaries and raise the quality of the present service program. The veteran should be helped to make a realistic survey of his situation. There is need to explicate the linking functions of various services. Linking does not just happen; it has to be planned. There should be more creative thinking in adapting service to each individual blinded veteran. We need not fear experimentation in a search to make services fit more closely the actual needs of the veteran. Miss Coleman asked for comments from some blinded veterans.

Gerald Boucher, a blinded veteran of the Vietnam War, spoke about the problems he faced at college--the attitudes of his peer group toward him. He summarized these attitudes as being "we're sorry you're blind, but it's too bad you went over there." He remarked that the opposite sex also seemed to feel this way, and it was this attitude that hurt him most. Gillispie asked him what the VA could do to help; to which he replied that it was up to him to learn to cope with the situation. A three-way conversation then ensued among Boucher, Gillispie, and Thompson, the gist of which was to find out how and when Boucher had received VA services. He said that on the advice of his VA counselor, he had spent the first year and a half out of service doing nothing, the purpose of this waiting period presumably being for readjustment. The talk then centered around other services such as equipment. It had taken him a year and a half to get all the equipment he had ordered. He talked also about a veteran's club that was formed at the college he was attending. He remarked that it was a great help to him.

Malamazian said that he had shortened the time lag for the delivery of equipment through the direct stocking of often-ordered items.

Glass raised the research question: to what extent are the characteristics of the blinded veteran of the Vietnam Era comparable to the characteristics of the general population of veterans? He went on to talk about adjustment, remarking that the extent to which the veteran is able to cope with this adjustment is a reflection of the extent to which he has been prepared at the rehabilitation center to deal with various kinds of real life situations. He emphasized that coping is related to reduction of psychological stress. Coping is especially important for the person of low vision because of the possibility of progressive sight loss. He concurred with Coleman's ideas about innovations and the need for them, agreeing that it would be a good idea if the blinded veteran were permitted, during the last month of his stay at the rehabilitation center, to live in an apartment in a relatively independent way.

Milton D. Graham spoke of the role of research; how it can describe and analyze factors that will alert people in the service and the operational side to possible problems and some possible solutions. He mentioned the fact that there are too many devices sitting on shelves which nobody knows are useful or not because there is no program to evaluate them. He compared the Vietnam group to the 851 Study[4] and noted that the Vietnam group was living largely at home or with relatives. He went on to note that in the 851 Study the group of men living alone who were in the lowest income bracket went for the least services and seemed the most isolated. Job placement must be looked at realistically in terms of the job market now and what it will most likely be in five years. Graham also commented on the meaningful use of leisure time and the necessity of learning how to use this time since we are going to have more of it in the future. Finally, he voiced a concern that the relatively small number of blinded veterans might cause them to be overlooked, despite the severity of their impairment.

REHABILITATION AND EDUCATION - LINKAGE WITH DEPARTMENT OF VETERANS BENEFITS

Morris Triestman spoke about vocational rehabilitation stating that from the start of the program in 1943, the VA had adhered to the principle of selecting occupational objectives which are suitable for the veteran in terms of his abilities, interests, and limitations. The range of suitable objectives for the blinded veteran is wide, including computer programming, teaching, cabinet making, small boat engine repair, as well as special programs such as vending stand operation. The provision of training assistance to disabled veterans has always been regarded as a responsibility to be handled by the best qualified staff. It is necessary throughout the rehabilitation process to keep the veteran moving through the various phases in order to get a suitable result.

It is frustrating for a blinded veteran to discuss his plans and his thinking and then find it necessary to change plans. The veteran might well wonder about the lack of communication between the centers and other rehabilitation and education programs in the VA. A letter was sent to the staff at all blind centers indicating how to find out more about each specific veteran. Hopefully, this will facilitate communication among staff.

There is a commitment to find veterans jobs in fields for which they have been trained. Suitable employment means compatible with his condition and consistent with his interests and abilities. Through effective coordination with the Department of Labor and the Civil Service Commission and the efforts of VA Rehabilitation and Education staff, they have been able to accomplish this for more than ninety percent of the veterans within six months of completing such training. He mentioned that they are able to continue to place about ninety-five percent of the veterans in suitable employment, but only by devoting a great deal of time to this function.[5]

The question was raised as to what happens to the veteran if his job is wiped out as a consequence of technological change.

Triestman replied that on the basis of training which the veteran has had, if he is able to work in another occupation which is compatible with his disability and reasonable for him to pursue, then he would not be considered in need of further training under Public Law 138 since he had been legally, under regulations of the VA, determined to be rehabilitated.

In the general discussion, Gillispie pointed out that the counselor who looks for a job for a blind person has compounded a blindism. This could be one of the biggest pitfalls that the Vietnam blinded veteran might fall into. He suggested that we should not counsel the blindness, but instead should counsel the man, and if the man wants to set the world on its ear with a lever, then by all means he should be given that lever.

When asked about the input to the Visual Impairment Services team, and about the linkage between vocational rehabilitation and the Department of Medicine and Surgery, Triestman responded that his staff is available through the VIS team, including counseling psychologists and rehabilitation specialists. A copy of Dr. Glass's summary is always sent to the VIS team chairman, along with a summary of the man's program.

Kathern Gruber commented that the BVA's concern is how a program is working as far as the blinded veterans are concerned. She expressed concern for the men once they have left the center and wondered how long it takes before anyone out in the field shows a real interest in what the veteran is doing.

Irvin Schloss asked whether each blinded veteran in each regional office is assigned to one counselor and one rehabilitation specialist. Is it policy to have a specialized rehabilitation counselor knowledgable about the blind?

Robinson wondered why one person could not be especially assigned to work with blinded veterans in Vocational Rehabilitation.

Triestman answered by saying that there is always a risk in becoming too dependent upon any one person. You must have the flexibility to know that more than one person can do the job.

Little commented, developing some issues: The only way in which prominence is reached in our society is by being controversial, by dividing people, not necessarily by bringing them together. He said that the Foundation and the BVA should be looking forward not merely to improving existing services and programs but to developing some sort of policy statement and a program that will look forward to all of the things that our society can do for the blinded veteran and in the larger sense for the blinded in general society. He noted that many things being referred to as differences in veterans are really differences between the societal contexts to which the veterans have returned in years past and the present time. Veterans are still normal human beings who are reacting differently to a different societal context. He remarked that today's society is primarily visual. He pointed to the fragility of family ties today, as compared to the times of the Korean conflict and World War II. He stated that in the past the solidarity of the nuclear family has been a reassurance to those who were handicapped in any way, or unemployed, or aged. Today that reassurance is not as strong because of looser family ties.

He also stated that the amount of money allocated for research, was equivalent to what in the behavioral sciences would hire a graduate assistant. Not only was the amount insufficient, but there was also a lack of coordination with other research efforts going on in government as well as in the larger society. The Special Warfare Laboratory has developed sensors so that soldiers in the swamps and jungles, deprived of vision because of the environment, are able to detect an enemy or environmental obstacle. Why couldn't something like this be adapted for the blind? Law enforcement people have allocated tremendous

amounts of money for surveillance mechanisms, and he suggested that it might be very easy to convert these mechanisms to the use of the blind. More contacts ought to be made between the VA and people concerned with research such as this.

Little referred to an emphasis upon a service frame of reference as opposed to what he called a discovery frame of reference. The limitations of the service frame of reference, the procedures and the evaluation of those procedures, as a means of doing things is really only a way of rearranging furniture and not of building a new house.

He cautioned against falling into the trap of believing that you need long experience with the blind in order to understand them. He pointed out in the history of medicine naive people confronting strange problems and coming up with developments that are ultimately more usable than the so-called experts might develop. He argued that one should keep the naive point of view to avoid becoming rigid in one's thinking. He also expressed the wish that the BVA, instead of reacting to what the VA is doing, should have an independent statement of what is required for the blinded veteran, an affirmative action program instead of support for existing policies.

BVA STATEMENT - CONCLUSIONS AND RECOMMENDATIONS

William Thompson spoke for the BVA, pointing out that after the staff had discussed the matter, they decided that the BVA's position now and hereafter, until it is changed, is to be what it has been. He reminded people that the BVA has tried to be an advocate, in the best possible sense, for the blinded veteran. He felt that the BVA could not afford to think only about what is going to happen in the next year or two; the BVA must be concerned with what is happening now with the delivery systems that have been discussed in past days. He went on to say that he felt the veteran deserves the highest quality of services possible to enable him to get back into the mainstream and compete with the sighted.

Robinson inquired whether the major problem was in what happens after the man leaves the VA system and returns to his community, rather than in what happens at the centers.

Malamazian mentioned various improvements that the VA centers had implemented: the family program, the low-vision program, the additional staff, and research. He talked about Hines specifically, pointing out that the Vietnam Era Veterans Committee has had veterans taking part in the decision making since its inception. He told of the spinal cord patients, the orthopedic patients, and the other patients asking for the privileges and benefits that the blinded patients have: fewer restrictions, privilege to play the radio all night, pass privileges, freedom to come and go to a certain extent.

In speaking of vocational rehabilitation, Thompson expressed doubts that the written agreements between the VA and the VR&E were being translated into job placement assistance. He wondered what proportion of the veterans they were talking about had applied for and had entered vocational training in the VA structure. He also expressed doubts about the coordination that these policies envisioned, and doubts that the veteran has the advocacy he should have within the VA structure.

Gruber asked why VA policies will not permit the specific assignment of a social worker to blind clients. She felt that there should be no time lag from the time that the veteran orders his prosthetic and sensory aids to the time that he receives them. She also expressed shock at the fact that the family programs are not funded by the VA. She felt that as valuable as they are, they should not have to depend upon outside funding to support them.

Robert Ward felt that from personal experience and from talking to other blinded veterans, he could not believe that the VIS team is exactly what it was said to be by some of the people at the meeting. He thought that much improvement

should be made and that it must start now. He saw no coordination between the two units of the VR&E throughout most of the country. The policy may be to have coordination, but he felt that it is not being carried out and that there must be more communication between these people. He thought that in most cases the linkages referred to earlier don't exist.

Schloss stated that the VA's being one system, theoretically, was ideal for providing services to every blinded veteran. However, there are problems inherent in every vast bureacracy; that which was ideal was not transformed into practice, that service gaps do exist. He said that the high degree of motivation with which the individual blinded veteran is instilled when he leaves the center and goes to his home area is vitiated by delays in adequate service, in ongoing contacts from the regional office personnel. He recalled that his training counselor kept at him after World War II, and he wondered if this kind of attention existed today.

Thompson spoke about the VA recruiting the type of individual who had an "accepting" kind of personality. He admitted to being unable to say how to single out this kind of person but he believed that training and experience with other than this kind of individual was a waste of time.

GENERAL DISCUSSION

Robinson suggested that the contemporary scene differs from that of his own past experience, and that perhaps World War II veterans have been talking too much and listening too little. Perhaps the BVA should be a little more militant rather than agreeing with the VA's policies and procedures.

Larson asked for suggestions that could help make the VIS team work more effectively. Schloss suggested an ad hoc committee that would cut across departmental lines. Mr. Larson advised him to put his suggestion in writing and send it to the VA so that they might know more precisely what he wanted.

In discussing the family programs at the VA centers, it was learned that several centers had trouble finding funds for such programs. None was funded by the VA.

Malamazian described the program at Hines. A month before the veteran leaves, the wife or mother is invited to the center, arriving on a Sunday night with the travel, motel, meals, and local expenses paid. The veteran stays with his wife at the motel. On Monday the wife is enrolled in a program at the center which includes observation, going to classes with the veteran, observing the veteran in his activities, discussing with the staff members the veteran's progress, his potential, and his limitations. She then meets with the psychologist, the social worker, and the veteran. The family member is trained in basic skills, taught how to use a sighted guide, and how to familiarize a person with an area. She experiences blindfolding, and subsequently instructs a staff member, who is blindfolded.

The three-phase program of observation, consultation, and experience lasting five days, costs $200 per person trained. The project is funded by the Military Order of the Purple Heart, and there is little difficulty in getting and keeping the project funded.

In discussing the kind of research relevant to the rehabilitation program of the blinded veterans, Coleman suggested that two or three year studies be made of case histories of a sampling of veterans from the time they move from the military hospital, into the center, and then into the community. The purpose would be to obtain exact data in order to identify the problems and then build services within these programs to solve them.

Larson mentioned the possibility that this might be done in line with the VA's "new found" research capability to be considered at VA Central Office during the summer. He mentioned that staff being freed from other research activities had expressed an interest in research along the lines mentioned above. Larson added that study was being done at the present time and that it was

hoped they would have something definite to announce by the fall of 1972.

Mr. Robinson said that he had investigated a program of research within the Veterans Administration--Cooperative Studies in Mental Health and Behavioral Sciences--and had asked Dr. Eugene M. Caffey, of the VA Central Office to corroborate the information gathered. Nothing had been done in cooperative studies on the subject of blindness, although he had been assured two years ago that such an undertaking would be carried out. Robinson asked Larson if the research he had referred to earlier was in fact a part of what had been discussed two years ago, or if it was something different.

Larson said he didn't know, that something was "moving." Williams said that he would connect it with the conversation of two years ago.

Apple commented that they have a cooperative study at the three centers to develop some knowledge about the factors that affect a man's staying in the program, his length of stay, and his general performance.

Robinson asked whether rehabilitation center people had any observations to offer with respect to the differences between the older veterans and the newer ones.

Apple thought that everybody's reactions are a little bit different toward the newer veterans. The new veterans seem to have fewer big differences in personality, are more intelligent, generally more stable and more consistent. There are fewer "oddballs," fewer drunks, and fewer fights. They seem to take very difficult things in stride. They cope with complicated inter-personal relationships and pressures that you would think would upset them. There had been no deaths at the centers as a consequence of the use of drugs.

The meeting was adjourned with an expression of appreciation to the participants.

NOTES

1. An article "Mystery Still Hangs over Etiology of Recruits' Retinitis," published in Clinical Trends, January 1972, sheds further light on this controversial condition.

2. Subsequently, Veterans Administration Central Office advised that the VIST Annual Report for the period ending June 30, 1972 would be published October, 1972.

3. The VA will release results of the evaluation studies of the laser cane early in 1973. RLR

4. Graham, M. D. and Robinson, R. L. "851 Blinded Veterans: A Success Story," New York: American Foundation for the Blind, 1968.

5. These percentages appear to apply to veterans generally and not just to blinded veterans. RLR

THE BLINDED VETERAN OF THE VIETNAM WAR: ANOTHER PROFILE

Robert Lee Robinson

To our knowledge, there has been no research survey published on the newly-blinded veteran of the Vietnam War. Therefore, in preparation for the conference on "The Blinded Veteran of the Vietnam Era" an attempt was made to obtain information about this group of recently blinded young adults whose health and physical well being was sufficiently adequate to enable them to become members of the military forces of the country. After onset of blindness, often coupled with additional impairments, what has happened to most of these young Americans?

To try to find out what has happened to the hundreds of newly-blinded ex-servicemen, I mailed an inquiry on January 14, 1972 to the Social Work Service Coordinator of the 72 Veterans Administration Hospitals where Visual Impairment Service Teams operate. The letter stated:

> "I am writing to you at this time to ask you to tell us what you have observed to be some of the characteristics of the newly-blinded veteran of the Vietnam War. We are seeking to improve our general pool of knowledge about blinded veterans returning from Vietnam.
>
> "Based on your experience and observations, is there anything you can tell us about this group of veterans?
>
> "Your cooperation will enable us to carry out a more effective conference focused upon newly-blinded servicemen."

The above inquiry was shared with Arnold Larson, Chief, Domiciliary/Restorative Social Work Programs, Social Work Service, Veterans Administration, who helped to formulate the text of the inquiry and who also communicated to all VIST Coordinators the following message from the VA Central Office:

> "Recently you may have received an invitation from the American Foundation for the Blind to submit some information on blinded veterans of the Vietnam War. If you decide to respond please send a copy of any material submitted to Social Work Service, Veterans Administration Central Office, Washington, D. C. 20420."

We have honored the VACO request to share materials we might wish to reprint and distribute. Of the 72 inquiries we sent out we received 28 responses and have excerpted from 15 of these materials which we considered appropriate and generally typical in content of most of the replies and have made these excerpts Appendix C of this book. At least 70 newly-blinded veterans are represented in these responses.

Little research appears to have been carried out by the Veterans Administration on blindness other than hardware research (sensory aids). However, the VA Cooperative Studies in Mental Health and Behavioral Sciences printed the following in their Highlights of the 16th Annual Conference, held in St. Louis, Missouri, March 22-24, 1971 in which I participated:

> "New developments in battlefield management and treatment of combat casualties have created serious problems for the VA in the care of the physically handicapped. There seems general agreement that our hospitals are receiving more physically handicapped veterans from the Vietnam war than had been received from previous combat. This group includes the blind, deaf, amputees, brain-damaged, and spinal cord injured. The psychological problems generated by these physical problems raise serious ques-

tions and enormous challenges for all treating personnel.

"...It seems essential to establish a realistic acceptance of the disability initially, before engaging patients in programs designed to help them adjust more appropriately to society.

"An early attitude of denial seems fairly universal among the seriously handicapped. Once the denial has been breached, however, patients typically become depressed as they recognize the permanence and hopelessness of their disability. At this time, the mental health personnel of the hospitals should be actively involved to help the patient work through the depressive component of his disability. Unfortunately, psychiatrists, psychologists, and social workers are not as involved in the physically handicapped treatment program as they should be in view of the important psychological parameters in every physical disorder. The workshop recommended that the VA should encourage its mental health personnel to take a more active role in treatment programs for the physically handicapped.

"Some great success has stemmed from using other handicapped persons in the rehabilitation program. They are able to effect instant rapport with patients and can display through their own adaptive efforts a more optimistic and realistic attitude toward the disability. In addition, the handicapped person is not actively struggling with his own guilt and depressive feelings, as many of the staff are, and which may be responsible for a subtle attitude of rejection on the part of treating personnel.

"It is important to separate the irreversibility of the physical disability with the remediability of the concommitant psychological problem...This is the area in which psychiatric personnel can play their greatest role by helping the physically handicapped and his family to accept his condition and develop alternative coping mechanisms that will enable him to fill a productive and vital role in society.

"There seems to be a dearth of follow-up data on the social, economic, educational, and psychological adjustment of the physically handicapped after leaving the hospital. We may do an outstanding job of bringing the patient to the point where he can be discharged and assume his place in society, but we do not have reliable statistics revealing how effective his long term adjustment has been. The VA needs to play a greater part in the community programs and provide a variety of continuing services to the veteran.

..."The workshop recommended that a cooperative study aimed at obtaining basic epidemiological data on the handicapped veteran in the community be initiated. They also recommended that the VA sponsor a large-scale evaluation program on the physically handicapped, analogous to the psychiatric evaluation project conducted on psychiatric patients. A final recommendation concerned the development of large-scale family assistance programs to aid family members in coping more effectively with the patient's disability. Many programs were criticized for focusing only on the patient and his needs while ignoring the importance of the significant other people in his environment. Very often the only hospital contact with the family has been to train them to manage the daily physical demands and medical needs of the handicapped patient. Families need assistance in understanding the psychological components of the disability and the problems of depression, rage, pessimism, and despair that inevitably accompany severe physical injuries."

A final comment is taken from a letter dated March 17, 1972 from Eugene M. Caffey, Jr., M. D., Associate Director for Psychiatry, Mental Health and Behavioral Sciences Service, which says:

"We have reviewed all of the annual conferences back to the first one held, about 17 years ago, and the only workshop on psychological problems of the physically handicapped was during the 16th conference."

RECENT DEVELOPMENTS

On September 13, 1972, exploratory talks between the Blinded Veterans Association (represented by David Schnair, Robert C. Ward, Irvin P. Schloss, William Thompson, and Robert D. Carter) and the Veterans Administration (represented by Donald E. Johnson, Warren MacDonald, and Russell Williams) were begun. The main focus of this meeting was discussion of a possible contract from VA to BVA to establish a Field Service Program.

On November 1, 1972, the Veterans Administration announced that such a one-year contract had been agreed upon and would begin immediately. The $100,000 agreement provides for a BVA project director in the association's headquarters in Washington, D.C., and for three field service representatives at geographically dispersed locations. The representatives will be blinded veterans and will be charged with contacting newly blinded veterans, especially young Vietnam-era veterans, in their communities.

The four will coordinate closely with the VA's own visual impairment services teams, regional office personnel, and the VA blind rehabilitation centers in West Haven, Conn., Palo Alto, Calif., and Hines, Ill. According to Robert C. Ward, BVA president, the project is intended to search out these individuals and to motivate them "to utilize the excellent VA and state services for them, to secure prosthetic devices and other aids for the blind that VA furnishes, and to conduct liaison with community leaders and look into employment opportunities where the veterans live. We will follow up when the blinded veteran goes to work or becomes active in community life. We want all blinded veterans to have the training at VA's three centers for the blind, the greatest places in the world for this kind of help."

VA administrator Donald E. Johnson said the VA-BVA agreement should make it possible to reach blinded veterans VA has been unable to reach or motivate, and that the one-year period could well be extended, depending on the first year's experience.

The VA-BVA agreement is under Contract No. V101(134)P-145.

Appendix A

Conference Agenda

Thursday, April 6

9:00 Opening Remarks:
Robert L. Robinson, Chairman

9:15 Combat Eye Injuries

Presentation: Col. Budd Appleton

Discussants: Dr. Roger Little
Col. Austin Lowery, Jr.

10:15 Break

10:30 Blind Rehabilitation (Veterans Administration)

Presentation: Russell Williams

Discussants: L. E. Apple
George Gillispie
Dr. Edward Glass
John Malamazian
Bobbe Vance

12:00 Luncheon

2:00 VIST Equals Outreach (Veterans Administration)

Presentation: Arnold Larson

Discussants: Virginia Karl
Santy Sacco
Robert Schultz

3:15 Break

3:30 Sensory Aids Research (Veterans Administration)

Presentation: Howard Freiberger

Discussants: William Thompson
Russell Williams

4:30 Adjourn

Friday, April 7

9:00 The Blinded Veteran Views Himself

Presentation: Nancy Coleman

Discussants: Dr. Edward Glass
Dr. Milton Graham

10:15 Break

10:30 Rehabilitation and Education - DM & S - Linkage with Department of Veterans Benefits

Presentation: Dr. Joseph Samler

Discussants: George Gillispie
Kathern Gruber
Irvin P. Schloss

12:00 Luncheon

2:30 BVA Statement - Conclusions and Recommendations

Presentation: William Thompson

Discussants: Kathern Gruber
Irvin P. Schloss
Robert Ward

4:30 Adjourn

Appendix B

Conference Participants

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Dr. Charles A. Stenger
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Veterans Administration Central Office
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Questionnaire Responses

In August of 1971 there were seventeen (17) blinded Vietnam veterans residing in the state of _____. The majority of these veterans have chosen to settle in small towns or in areas in the central or western part of the state. Currently at the _____ VA Hospital we have four (4) Vietnam veterans receiving Visual Impairment Team Services.

The first of these is a career Army veteran, age 40, who has not responded to inquiries since 1970. At that time while talking with a team member he expressed the desire to return to his home and family in Georgia. We have not had a request for transfer of records but when it comes they will be forwarded to the appropriate hospital and arrangements made for continuing Visual Impairment Services.

Another young Vietnam veteran (24) is attending computer training in the _____ area. He, however, is still carried by our team because during visits to his family in the _____ area he receives his medical care here. He is doing exceedingly well in the training and it is my understanding he is second in the class. The person that is ahead of him is sighted. He has not yet chosen the area he would like to reside in but is considering Arizona or Ohio depending on the employment situation at the time of his completion of training.

Another Vietnam blinded veteran (25) completed rehabilitation training this fall at the state school of the Blind at _____. He was married just before completing his training. For a short time after graduation, the newlyweds lived with his parents but now have purchased their home. He has started working for Western Electric in _____ County.

The last Vietnam veteran (27) on our program had already received his bachelor's degree before being wounded in Vietnam. On his return from service he took various courses at the University of _____ including some in business, although his undergraduate training was in architecture. Since his return from the service he has married and they have had a child. Currently he is not working nor training but is doing some traveling and enjoying spending time with his family.

* * *

The Visual Impairment Services Team at this clinic has only recently been activated with the availability of staff.

Very few Vietnam Era veterans have received service through the VIS Team. Our experience with Vietnam Era blinded veterans is so limited that it would not be safe to generalize from our experience. However, we have been fortunate in finding that these young men are eager to make the best possible adjustment to their handicaps and to get on with their lives as students, husbands, fathers, providers, etc.

The observation that blind veterans are unresponsive to regimentation and to authority which cannot be explained to them is more or less characteristic of today's young people generally and it would, of course, be unrealistic to expect that a veteran would not fit this pattern simply because he is without sight.

We look forward to continued cooperation with the American Foundation for the Blind and with the Blinded Veterans association.

* * *

We are writing in response to your recent letter inquiring as to our observations of the newly blinded veterans of the Vietnam War....We have been aware of their bitterness, their lack of identification with "The Establishment" and also the lack of recognition received from their peers.

We have been struck by the extreme youth of many of these veterans, and their concern and sensitivity regarding their blindness, as it may affect their body images and their attractiveness to the opposite sex. Since many of them are unmarried there has also been fear around the prospect

of finding a girl who wouldn't "just pity me."

We have found a fair number of young blinded veterans who are productively involved in working, or in furthering their education, and probably are at least as goal directed as the sighted veterans we have seen in this age group. Those individuals who have not availed themselves of rehabilitation and education benefits through the Veterans Administration, we have found, were fully aware of their entitlement to these benefits. Their reluctance to become involved has often been due to denial of the problem or lack of motivation, rather than due to reality problems which precluded their following through on this. Particularly the more immature individuals find their compensation adequate to meet their needs and this contributes to further lack of motivation.

We have generally requested social service follow-through from our VA field social workers for the blinded Vietnam veterans. However, we are also aware of the veterans' sensitivity about over-protectiveness and we have also tried to respect this. Also, there has been a great deal of interest directed toward this group of veterans, with the result that sometimes there has been duplication and overlap, which at times have confused and annoyed the veteran. We see a need for coordination of the interested individuals who are attempting to serve them. We have also observed that some of these young blinded veterans, particularly those who have a great need to deny their blindness, do not want to be identified with groups of blinded persons, which has also precluded their becoming involved in groups such as BVA and, or rehabilitation programs at Blind Rehabilitation Centers.

We hope that this may be of some help to you, and look forward with interest to the findings of your coming conference on Blinded Veteran of the Vietnam War.

* * *

In your letter a comparison seemed to be made between the Vietnam veteran and the WWII veteran. Let us remember that the WWII veteran usually was a product of an unprecedented depression era whereas the young Vietnam veteran is usually the product of unprecedented time of prosperity. This, I believe, has a great deal to do with the difference in attitudes, personalities, general outlook, and even to the acceptance of blindness.

In a sense the Vietnam veteran is more aware of benefits that have been made into law for him by the Congress of the United States and he is usually more demanding than his predecessor. He is less accepting of regimentation merely for the sake of regimentation but is able to accept reasonable requirements.

Of the nine Vietnam veterans on the roll at the VA Outpatient Clinic, _____, five of these were blind due to injuries in direct combat whereas the remaining four are due to disease or injury not related to combat. Five of these are shown to be continuing their education above a high school level or intend to do so as soon as they are physically able. One veteran considered to be severely blind showed his resentment toward being labeled blind by returning some of the mechanical apparatus to assist him because of his blindness ie, a Talking Book Machine was issued to him and he returned it merely because it was supposed to be for a blind person.

Only two veterans of the Vietnam war in this area have expressed interest in attending the Blind Rehabilitation Center and only one of these have successfully completed a period of training. Perhaps it is too soon or too early to determine if the Vietnam veterans are rejecting the Rehabilitation Center. The attitude seems to be "Let me see what I can do on my own."

* * *

Reference is made to your letter of January 14, 1972. The only experience I have had in coordinating a Visual Impairment Service Team has been in _____. Therefore, my experience is limited to the small population we serve, which consists of 28

blinded veterans, six having served in Vietnam. We find it significant in _____ that within the past three or four years a number of WWII veterans have entered into training, as well as four of our Vietnam veterans. One of the four left training as a result of social-emotional problems he is experiencing.

It is my impression that an active Visual Impairment Service Team, coupled with an active rehabilitation counseling program, makes the difference in helping to motivate veterans to utilize those resources available to them. Periodic home visits by a social worker is also important. It requires a great deal of skill in providing these services, a fact I think we sometimes forget. Obviously it is important that we convey a positive attitude towards rehabilitation. This requires using the best skilled and adjusted staff available, who either have the natural ability to serve the severely handicapped or who will work to develop this ability.

I strongly endorse the idea that we must go out of our way to serve the blinded veteran through close follow-ups, both in the community and our clinics, and, while not being very original, I further suggest that when we can't get a veteran into the clinic, we should start taking the clinic to the veteran.

* * *

In reply to your recent inquiry re: "Characteristics of newly blinded veterans of the Vietnam Era", our experience in _____ has been limited to five (5) young veterans who meet this definition. While this is a very small number, our VIS Team personnel at this Clinic, as well as at our local VA Hospital, have noted a wide variety of responses among even this small group.

They vary in attitude from the totally cooperative, realistic, young veteran who avails himself of the numerous VA facilities, resources and "know-how", in his goals of rehabilitation; to the veteran who equates VA with "The Establishment"; "wants none of it", and is convinced we are a non-functioning bureaucracy dedicated to non-help!

Interestingly enough, this latter group of Vietnam veteran (observed among both the blinded and sighted groups) seem to almost (unconsciously?) sabotage much of the VA effort and outreach on his behalf, thus "proving" his prior conviction that governmental institutions will not be responsive to his needs.

How to more effectively deal with this problem? Perhaps a peer group of Vietnam veterans, with a "positive" orientation to VA and other governmental benefits (educational, medical, social, rehabilitation) could provide some direction and guidance towards re-focusing our outreach to the non-responsive young men.

One should also give serious consideration to the pre-military personality and functioning of the non-cooperative veteran; his motivations, feelings and attitudes about military service; and what he sees as his current goals and value system. Perhaps with this awareness we can then more effectively deliver to these young men the services to which they are entitled.

* * *

Our VIS Team has found the blinded veterans of the Vietnam War have their life adjustment problems compounded not only by their multiple injuries but by the negative attitudes of the general public to our involvement in Vietnam. Instead of the respect and acclaim given to World War II veterans upon their return home, the Vietnam veterans are oftentimes met with indifference or derision. It is not unusual to find hostility, negative attitudes and lack of motivation in the Vietnam Veterans, both with and without sight. Many barriers must be overcome if we are to be successful in involving these young men in our treatment and rehabilitation programs. We must "reach out" to them and not give up in our efforts to be a real assistance. Our programs should be tailored to their needs and not the needs of veterans of other wars.

One way our VIS Team meets the needs of our blinded veterans of the Vietnam War is to provide more direct contact with them and their families

in their own home and in their own communities in order to stimulate their interest, motivation and co-operation. We have found these veterans have not been motivated by letters. They need and should have personal contact with VA personnel. In this particular way, social workers are well prepared and ready to render a valuable service.

We have 65 blinded veterans who are eligible for services under our Special Program for Blinded Veterans. Of these, only six are of the Vietnam era. These range from 24 - 35 years of age. With such a small number, it is virtually impossible for me to contribute any significant information relative to unique characteristics of the newly blinded veterans.

Of these six Vietnam Veterans, only one (age 35) showed some of the characteristics mentioned in your reprint enclosure. ("The Blinded Veteran of the Vietnam War: A Profile," by Robert L. Robinson. New Outlook for the Blind, 1971, 65, 287-290). This Veteran's problems were not solely due to his loss of vision but rather dealt with various emotional and personality problems having little relationship either to his military service or blindness.

Another Veteran, age 25, parallels the example of Joe as given in the reprint. This Veteran also was extremely unmotivated and only through much effort and support was I able to interest him in getting his high school certificate and apply for VRE Training. However, he still refuses to accept training at the rehabilitation center in our VA Unit at Hines, mainly because he has not accepted his blindness as fact. He prefers to use the residual vision which he has rather than accept the "stigma" of sightlessness.

Another Veteran, age 27, has a degree in engineering and also had intense resistance toward accepting his blindness. He has tunnel vision and his reluctance to face reality was so great that he even drove his car 83 miles to the VA Hospital to see the Ophthalmologist. He too, refused all offers for training at Hines.

Of the six Vietnam Veterans, one had a degree in engineering as mentioned above, and another had a degree in geology, and both have sufficient residual vision to continue in their former professions and are making good industrial adjustments. Two others accepted training at Hines and both plan to enter training with some trade objective. Two Veterans were too incapacitated to be involved in training.

None of the Veterans have indicated any community, family or social pressure to "achieve." With the one exception above there have not been any instances of resistance to services offered by the VA and I have not noticed any indication that they equate VA help with the authority of the Military Services.

As a group, these Veterans were not excessively demanding. They accepted the recommendations and suggestions made by doctors for treatment and have reported faithfully, consistently, and cheerfully for all appointments. This is true in spite of the fact that for those with multiple impairments, there have been many tiring visits to the hospital, with long and wearisome waiting periods.

None of the six ever discussed their war experiences or volunteered information concerning the circumstances surrounding their loss of vision.

The Vietnam Era Veterans' reluctance to discuss war at all is really the only significantly different characteristic I have found.

I have found in my contacts with these Vietnam Era Veterans, that the much publicized drug abuse is not playing any part in their adjustment.

* * *

In response to your request, we are pleased to hear of the research being carried on in this worthy cause. We, too, feel that this is an area which needs closer scrutiny.

It is obvious that we are not meeting the needs of these young men, not due to lack of available facilities, but seemingly due to lack of either communication or our under-

standing of what they would be interested in.

Our area produces a more limited number of blinded veterans than may be seen in larger metropolitan areas, as our entire service-connected blind program covers just over a hundred active blind veterans. At the present time we have only three Vietnam veterans on our program--one a veteran of 19 years service, and two young veterans, one with a drug problem. These do not seem to be typical of the type we hear are returning.

We are anxious to be of service to you. We would be interested in some feedback on the conferences that are being held, as we feel this will be of benefit in our Outreach Visual Impairment Services Program.

* * *

It pleases me to write you about the series of rehabilitative programs adopted by the Veterans Administration which has changed this distressing picture into positive action.

Since its inception, the Veterans Administration has made financial, educational and counseling benefits, along with prosthetic equipment, available to the blinded veterans. After World War II, the Blind Reorientation Center was established to aid in the adjustment to blindness. There are now three such facilities, one in West Haven, Connecticut; Chicago, Illinois; and Palo Alto, California.

The recent program addition, the Visual Impairment Service Team, now provides the continuous follow-up on these veterans after returning to their home communities. A concerted effort is made to work with them on any problem the veteran faces and is willing to tackle. The Visual Impairment Service Team consists of Ophthalmologist, General Physician, Audiologist, Social Worker, Prosthetic Specialist, Contact Representative and Vocational Counselor. There are presently 71 Veterans Administration Hospitals and Outpatient Clinics providing these professional services which add more completeness and balance to the rehabilitative service delivery of the Veterans Administration to all blinded, service-connected veterans.

* * *

1. In response to your correspondence of January 14, 1972, I would suggest that the thirteen young Vietnam War blinded veterans we have on our rolls in Virginia do not seem to fit the general description of a blinded Viet Nam veteran.

2. We have found that the newly blinded young veteran because he usually has many multiple impairments has many psychosocial problems to overcome but casework by our social workers with both clinic and home visits have helped him make adjustments. Our casework has had to be rather aggressive ("reaching out") but with appropriate relationships and the use of VA and community resources; response to getting help has been generally good.

3. Since the home visits seem so valuable, we are increasing this service and we hope to see these veterans more often.

4. A danger for any handicapped person is to isolate himself and become depressed. We must reach out to the handicapped, particularly the Vietnam veteran who is not a "war hero" in our society now, and let them know we do care. The handicapped person must want to help himself; we can only offer relationships and opportunities with the necessary "tools" to take advantage of the opportunities.

5. In answering some of your questions I point out that of our thirteen blinded Vietnam veterans, four have been through our Blind Rehabilitation Centers; one withdrew because of emotional problems, and one attended a state center. Several others are in casework treatment to help prepare them for admission. Only one is too severely handicapped to attend a B.R.C.

6. When the newly blinded veteran leaves the VA system and returns home he is placed on our list of such veterans for our Visual Impairment Services Team to follow. Home visits are made periodically to follow progress, give casework services, make

referrals for VA and local benefits, and once each year he is called into VA Outpatient Clinic for a complete medical examination, review of prosthetic and sensory aid needs, and further Social Work Service needs. the VIS Team reviews the case to determine their needs and the best way to meet them.

7. Referrals are particularly made to our VA Vocational Counseling and Training Activities Unit at the VA Regional Office. Three have been in training and others are being counselled. One completed high school and two are in graduate school training.

8. Three of our thirteen newly blinded veterans are working full time in remunerative employment and six are still having serious psychosocial problems with their disabilities.

9. Again I cannot stress the importance of reaching out to our blinded Vietnam veteran in their home communities. With their severe handicaps, their ambivalent feelings about receiving them, and sometimes hostile, or apathetic response from the general public about the military and plight of veterans, the newly blinded veteran needs all the help he can have extended to him by people who care.

* * *

The Coordinator of the Visual Impairment Service Team in our station has informed me in regard to the communication sent by you that to date twelve Vietnam veterans with visual impairments have been seen by him.

All of them are facing some sort of psychosocial problem varying from light discomfort to more serious emotional conditions and have its etiology in/or at least related to their respective visual limitations. Three of them are pursuing education at a college level and one is going to a vocational school. None of them are working in remunerative positions. Two of the veterans have received rehabilitation services from this station.

With such a small number of patients, we do not feel that we are in a position to evaluate attitudes toward the program and/or "the establishment" in general. At least one of them has verbalized his dissatisfaction toward procedures they have to follow in getting some of the services ("prosthesis") and referred to it as "red tape" and "bureaucratics". Two of these patients discussed the possibility of organizing the local Chapter of the Blinded Veterans Association which might be used as a tool in the implementation of a wider community program. Our social worker who acts as Coordinator of the VIS Team expressed his willingness to help toward this objective.

This station is seeing all blinded veterans in its VIS Program and special attention is being placed on the Vietnam Era veterans in accordance with the policy established by our Administrator.

* * *

I am writing in response to your recent communication regarding plans that you are making for a conference on the above subject.

I do feel there should be some distinction made between the blind Vietnam Era veteran and the veteran returning from Vietnam blind. In our limited experience the veteran who suffered sudden blindness as the result of trauma has by far the greatest difficulty in making the transition to civilain life and adjusting to his handicap. The majority of those seen by our Visual Impairment Services Team do have some remaining vision and have experienced a gradual onset of their visual impairment. In this latter group we find the veterans showing more willingness to accept and involve themselves in our follow-up and offer of help. Again, this is based on a rather limited number and may not hold true throughout the country.

I cannot comment on the post-World War II method of providing special rehabilitation counselors for the blind, however in our area we do have vocational counseling and training personnel who are working closely with our Visual Impairment Team with the blinded veteran.

* * *

At the present time we have only seven Vietnam veterans on our blind roster (visually impaired, service-connected veterans entitled to annual examinations under M 2, Part I, Change 29) and we have worked with all of them more or less closely around various problems. Generally speaking, our relationships with these young men have been spasmodic.

Only one of the seven, a young man who interrupted his training at the VAH, Hines, Ill. and subsequently rejected contacts for an extended period with us, VCTA and state vocational rehabilitation, demonstrated any real resistance to professional help. This young man just recently matriculated at a local junior college.

Two others have been helped to accept in the past six months blind rehabilitation training at the VAH, Hines. One of these has shown a tendency to be hypercritical of delays in the delivery of aids and services, not always without provocation. The other, while being critical of certain imagined or real conditions at Hines definitely recognized it as a positive worthwhile experience.

A fourth Vietnam veteran, currently in college and who had abbreviated training at Hines, last year displayed a neurotic concern that he was developing a serious hearing deficit despite the fact that there was no objective evidence of this either in his school adjustment or in the results of several audiological examinations. Of the remaining three, one is in his last year of college, the second is employed full-time as a construction worker and the third is idle.

We have seen all of these veterans several months after their traumatic loss of sight and their initial adjustment to blindness. Only two would appear to us to be experiencing continuing problems of adjustment to their handicaps. The others seem to have accepted their handicap and have eagerly gone about the business of making new lives for themselves. The ready and easy availability of blind aids and services, a rate of compensation that virtually eliminates security fears and an ongoing relationship with VA personnel have hopefully been important factors in this process.

We have not uncovered any feelings that are traceable directly to disappointment with their post-service reception. At the same time we would agree with the logic of your thesis that the visually impaired from a conflict as divisive as the one in Vietnam might be expected to show resentment when they encounter civilian indifference to their sacrifices.

* * *

1. The Vietnam Veterans who are blinded have all been direct referrals from either the Blind Rehabilitation Centers or as in one situation another VA Hospital. There have been four blinded Vietnam veterans referred of whom two have had drug related problems. Along with having drug problems these veterans faced the difficulty of finding a job. Family life became disrupted along with marital problems. Two blinded veterans who had received special training at a Rehabilitation Center are both doing well and will return for the new electronic sensory aid.

2. Your letter raises the real question of what is really happening to blinded veterans upon their return home to the community. The frustrations of being blind is only one aspect of a total life situation where family, friends, job, drugs, and motivation are pieces of the total picture. I suspect a careful study may reveal that the blinded veteran's personality prior to becoming blinded will significantly determine his basic attitude toward rehabilitation and continued training.

* * *

We appreciate the opportunity to contribute to your conference on the subject of the newly blinded veterans of the Vietnam War. Your conference theme is a timely one. It is also of uppermost interest to those of us assisting in the rehabilitation of this group as well as the nation at large. We offer comments based upon our experience in working with the

newly blinded veterans residing in _____. These comments are the collective thinking of members of the Visual Impairment Service Team, _____, Chief, Vocational Counseling, Training and Adjustment Section, his Staff of the _____ VARO, and from my experience serving as the Chairman of the Vietnam Era Committee at our hospital, as a participant in several workshops and conferences on Services to Vietnam Era Veterans, as coordinator of our Visual Impairment Service Team and in the provision of direct services to these veterans.

The attitudes of the Vietnam blinded veteran is similar to that of the other severely disabled veterans of this period of service. They seem to lack the feeling of patriotic accomplishment that was observed with veterans of prior conflicts and wars. There does seem to be more of a tendency to blame their disablement on the circumstances of what they perceive as an unpopular war. Those who have been involved in motivating all seriously disabled veterans to participate in counseling and training programs consistently find this group to have feelings of dispair that are overwhelming. They have a tendency to handle these feelings by failure to take advantage of the rehabilitation services that are available. Even those who become involved drop out of programs in a short while.

Those who leave the Rehabilitation Center with well thought through plans for rehabilitation soon develop negative feelings when confronted with the realities of their home environment. A return to the Center has not been found to be the solution. We feel an extension of the Rehabilitation Center services would help in the readjustment experience. We also feel more group involvement on a community level would compliment other rehabilitative efforts. Perhaps your Foundation Staff could provide these services. These could include opportunities for group socializations with other blinded persons, veterans, and non-veterans. Your group could further serve as consultants, to all agencies concerned with the blinded. We feel there is no substitute for the personal contact and associations that follow. We would encourage and support your Foundation in reaching out to this group in this manner in addition to your program of literature, etc. A meeting such as you plan would be worthwhile if held in each state or region.

* * *

We feel there were no "professional rehabilitation counselors" after World War II. The profession of rehabilitation counseling is relatively new and only developed since WWII. Today's VA rehabilitation counselor is a trained counseling psychologist with special competence in counseling the disabled. There is still an active program to reach out to the severely disabled veteran and help him become involved in vocational rehabilitation training.

We agree there is need for expanded services to the blinded veteran. We are pleased to share our experiences and concerns with you and feel a conference of this kind will prove mutually beneficial.

Each Visual Impairment Services Team does have a trained social worker as a member whose assignment includes referral responsibility for outreach ongoing casework services. We do not anticipate the service-connected blinded veteran will ever "leave the VA system" until he has demonstrated his ability and confidence in adjusting to a meaningful satisfying life. The services of Vocational Counseling and Training are readily available, and they are more knowledgeable and aggressive than 25 years ago.

The relatively recent advent of the Vietnam Era veteran does produce room for unanswered legitmate questions in many areas. As they are answered they may well cause us all to adjust and re-adjust to ensure satisfactory answers.

Our experience with the blinded Vietnam veteran is quite limited at this station. To date, we have had only four Vietnam veterans who qualify for the services of the Visual Impairment Services Team, and these contacts have been of short duration. All four are moving through

the very difficult transitional period.

Three of these men are known to the _____ Commission for the Blind and the fourth has completed training at the Blind Restoration Center, VA Hospital, Hines, Illinois, and has been referred for follow-up casework services. Of the former three, one has completed the Iowa Commission for the Blind training program; one is presently enrolled and the third has been reluctant to give up his employment in order to enroll in either blind training program.

As mentioned above, one is employed, one in college and two are planning to enroll in college. One of these two already has a Bachelor of Arts degree.

All of these men are outpatients and we have not had in-depth contact with which to evaluate the kind of findings suggested in this reprint. Individual social workers with outreach responsibility will be assigned each of these men for ongoing casework services where duplication of service is not involved.

Each of our men appears to be preparing for an independent future, not enmeshed in self-pity or bitterness or lacking in self-confidence.

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